JRCPTB
Joint Royal Colleges of Physicians Training Board

Training in palliative and end-of-life care

Guidance for trainees (and their trainers) in non-palliative medicine training posts

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Background

Physicians practising in general internal medicine (GIM), acute internal medicine (AIM) and most medical specialties commonly manage illness in patients who may be in the last phase of their lives, both as inpatients and outpatients, and decision making about their preferences for treatment and care should routinely be a joint process with patients and their families. Ensuring that this is the normal or default approach, coupled with specific attitudes and skills to manage end-of-life care (EoLC) discussions sensitively and manage symptoms optimally are core attributes of good doctors[1]. The key competences expected are shown in the curriculum extracts in section four.

There are approximately 6500 trainees in higher training (ST3 and above), up to 50% of whom undertake dual training with GIM. Most of these will require some palliative care (PC) skills for patients in the last phase of life (LPoL) which may range from hours/days to many months. The UK annual intake of trainees requiring these skills amounts to about 1000 pa. At deanery level, this means that on average there will be 80 trainees eligible for enhanced training per year, but the numbers will vary from 20 - 150 pa depending on the size of the deanery / LETB.

Specialties requested guidance for *how* the required competences can be gained for use at training programme level. This document focusses on the training methods rather than the competencies required.

Guidance for trainees, trainers and programme directors

Although the curricula are competency-based, there is also a minimum indicative time required, recognising that experience is very important in gaining competency. The following excerpt from the **geriatric medicine** curriculum suggests how competency can be gained:

- *Work directly with a consultant-led palliative care team on a full-time or part-time basis (eg one day per week over four-five months)*
- *Assess new and follow-up patients and discuss with educational supervisor*
- *Work within a variety of settings eg hospice, specialist palliative care unit, day hospice, general hospital outpatients*
- *Attendance at specialist palliative care MDT meetings*
- *Small group sessions with other trainees (Geriatrics and/or Palliative Care)*
- *Education Courses - Palliative Care, Communication*
- *Reflection in log-book/e-portfolio*
- *Participation in audit and research*

Although elements of the competencies required will be gained at various times, it is useful to specify a minimum requirement so that trainees and trainers can identify needs and demonstrate competencies gained.

[1] http://www.rcplondon.ac.uk/projects/future-hospital-commission

It is anticipated that the *minimum* indicative time requirement to gain the curriculum competencies will be 40 hours (equivalent to five working days). Time spent on the WPBA (and associated feedback) can be included.

It is recommended that a minimum of two supervised learning events (SLEs) are carried out (at least one CbD and one mini-CEX) which predominantly relate to palliative care and EoLC issues. Examples of topics to be covered are listed below. Once the trainee believes that they have adequately explored the competencies they should complete the 'trainee rating' section of the curriculum grid in the e-Portfolio. This should be reviewed by the supervisor (clinical or educational) and the competency status confirmed.

Guidance for how to achieve (and document) a minimum competency level, and some examples of excellence is outlined in the table below.

Domain and indicative time	**Examples of how knowledge, skills & behaviours can be achieved**	**Minimum requirement to demonstrate exploration of curriculum**	**Examples of excellence**	**Assessment methods**
Knowledge **8 hours**	Personal reading, eLearning (see below), attendance at formal lectures / grand rounds / seminars / tutorial, any relevant CPD	At least 3 hours of specific, formal palliative care teaching / lectures	MSc / Diploma / certificate / approved course	CbD Mini-CEX SCE
Skills and behaviours **16 hours**	Reflection on personal involvement with patients / PC / EoLC events Communication skills course Use of simulation Use of patient /family feedback about the extent to which they feel involved as a part of reflective learning	Initiate a discussion about EoL (more than BBN) Manage a patient's care through their last days of life according to the principles of an agreed EoL care plan Generic communication skills course Demonstrate patient led decision making and attaching value to patient preferences	Advanced communication skills course Review of hospital complaints re events surrounding deaths Write a discussion / reflection document (case, ethical / comm dilemma/ reflection on patient feedback) Participate in audit / QI project	MSF Mini-CEX ACAT (eg care of patients seen during attachment) DOPS (eg syringe driver prescription / set up) AA/QIPAT
Experience **16 hours**	Period of time / sessions with a PC team (hospice / hospital / community) where assessment of patients with PC needs is undertaken Attend M&M meetings Opportunistic joint visits with palliative medicine colleagues/patient assessments and reviews on wards or in outpatients	2 sessions (of at least 3 hours each) or equivalent, with a palliative medicine team (community / hospice or hospital) with documentation of, and reflection on, experience and feedback	2 weeks Experience with specific MDTs (eg GP GSF meetings) Visits with District Nurses and day centres Bereavement teams Detailed documentation of skills gained and development needs	ACAT CbD Mini-CEX

Suggested topics for mini-CEX (adapted from the palliative medicine curriculum)

1. Communication with patients and families (eg BBN, developing a joint care plan with a patient covering the last months of life, advance care planning, DNA-CPR)
2. Clinical evaluation / examination for symptom management, including emergencies
3. Supporting a family in conflict in relation to unrealistic goals
4. Assessing the dying patient
5. Clinical evaluation and on-going care of the dying patient
6. Prescribing in organ failure
7. Evaluation of psychological response of patient & relatives to illness and supporting patients' needs
8. Evaluating and supporting spiritual and religious needs
9. Supporting patients to make their preferred choices and manage own their health needs

Suggested topics for CbD (adapted from the palliative medicine curriculum)

1. Shared decision making in the management of symptoms / clinical problems (including intractable symptoms and emergencies)
2. Pharmacology / therapeutics, including opioid use and opioid switching
3. Other interventions in pain management
4. Recognition, assessment and management of critical change in patient pathway
5. Management of concurrent clinical problems
6. Psychosocial care and support in relation to distress, grief and bereavement
7. Communication with colleagues and between services, shared care
8. Ethics
9. Team-working

E-Learning sessions recommended to support curriculum delivery

www.e-lfh.org.uk/projects/end-of-life-care/

Course Section	Session Code and Title
Advance Care Planning	01_01 Introduction to principles of ACP
	01_05 Advance Decision to Refuse Treatment: principles
	01_12 How to get started and get the timing right
	03_15 Breaking bad news
	04_23 Recognising the dying phase, last days of life and verifying death
Integrating Learning	05_01 Initiating conversations about EoLC: COPD
	05_03 Initiating conversations about EoLC: dementia
Spirituality	08_02 Understanding and Assessing Spiritual Need and Spiritual Distress

Future possibilities

Consider incorporating questions into knowledge-based assessment (KBA).

Curriculum extracts

Tables 1-3 below are taken from the current curricula for CMT, AIM and GIM curricula and detail the knowledge, skills and behaviours required for palliative and end of life care training.

The following curricula also contain syllabus sections on palliative medicine:

- Cardiology – End of Life Care in Cardiology, page 63
- Geriatric medicine – Palliative Care, page 70
- Gastroenterology – Management of patients requiring palliative and end of life care, page 56
- Haematology – Palliative Care, page 90
- Infectious diseases – Management of Patients Requiring Palliative and End of Life Care, page 18
- Immunology curriculum – Palliative Care, page 91
- Respiratory medicine – Palliative Care, page 131
- Stroke medicine – To provide appropriate end-of-life care for stroke patients, page 15

Table 1: Management of Patients Requiring Palliative and End of Life Care *CMT*

To be able to work and liaise with a multi-disciplinary team in the management of patients requiring palliative and end of life care.

To be able to recognise the dying phase of a terminal illness, assess and care for a patient who is dying and be able to prepare the patient and family.

To be able to support patients to develop an appropriate management plan and facilitate planning of EoL choices including advance care planning

Knowledge	Assessment Methods	GMP
Describe different disease trajectories and prognostic indicators and the signs that a patient is dying	MRCP(UK) Part 1, Part 2, ACAT, CbD, mini-CEX	1
Know that specialist palliative care is appropriate for patients with other life threatening illnesses as well as those with cancer	ACAT, CbD, mini-CEX	1,3
Describe the pharmacology of major drug classes used in palliative care, including opioids, NSAIDS, agents for neuropathic pain, bisphosphonates, laxatives, anxiolytics, and antiemetics. Describe common side effects of drugs commonly used	MRCP(UK) Part 1, MRCP(UK) Part 2, ACAT, CbD, mini-CEX	1
Describe the analgesic ladder, role of radiotherapy, surgery and other non-pharmacological treatments	MRCP(UK) Part1, Part 2, ACAT, CbD, mini-CEX	1
Describe advance care planning	CbD, mini-CEX	1
Knowledge of a spectrum of professional and complementary therapies available, e.g. palliative medicine, hospice and other community services, nutritional support, pain relief, psychology of dying.	CbD, mini-CEX, PACES	1,2
Know about End of Life Integrated Care Pathway documentation	ACAT, CbD, mini-CEX	1
Know about the use of syringe drivers	ACAT, CbD, mini-CEX	1
Outline spiritual care services & when to refer	CbD, mini-CEX	1
Describe the role of the coroner and when to refer to them	ACAT, CbD, mini-CEX	1

Skills		
Recognising when a patient may be in the last days / weeks of life	MRCP(UK) Part 1, Part 2, ACAT, CbD, mini-CEX	1
Be able to assess the patient's physical, psychological and social needs	ACAT, CbD, mini-CEX	1
Is able to take an accurate pain history, recognising that patients may have multiple pains and causes of pain	ACAT, CbD, mini-CEX	1
Is able to prescribe opioids correctly and safely using appropriate routes of administration	ACAT, CbD, mini-CEX	1, 2
Able to assess response to analgesia and recognise medication side effects or toxicity	ACAT, CbD, mini-CEX	1, 2
Is able to assess and manage other symptom control problems including nausea and vomiting, constipation, breathlessness, excess respiratory tract secretions, agitation, anxiety and depression	MRCP(UK) Part 1, Part 2, ACAT, CbD, mini-CEX	1
Recognise that the terminally ill often present with problems with multi-factorial causes some of which may be reversible	MRCP(UK) Part 1, Part 2, ACAT, CbD, mini-CEX	1
Communicate honestly and sensitively with the patient (and family), about the benefits and disadvantages of treatment and appropriate management plan, allowing the patient to guide the conversation. Able to elicit understanding and concerns.	ACAT, CbD, mini-CEX	1,3,4
Is able to document discussion clearly, and communicates relevant parts to other involved carers appropriately.	CbD, mini-CEX	1,3
Practice safe use of syringe drivers	MRCP(UK) Part 1, Part 2, ACAT, CbD, mini-CEX	1,2
Complete death certificates and cremation forms	ACAT, CbD, mini-CEX	1
Behaviours		
Co-ordinates care within teams, between teams and between care settings	ACAT, CbD, mini-CEX	1,3
Active management, regular review of patient priorities and preferences, and on-going assessment of symptoms	ACAT, CbD, mini-CEX	1
Refers to and liaises with specialist palliative care services when recognises that care is complex	ACAT, CbD, mini-CEX	1,2,3

Table 2: Management of Patients Requiring Palliative and End of Life Care *AIM & GIM*

To be able to work and liaise with a multi-disciplinary team in the management of patients requiring palliative and terminal care. **To be able to recognise the dying phase of a terminal illness, assess and care for a patient who is dying and be able to prepare the patient and family.** **To facilitate advance care planning, the establishment of aims of care**		
Knowledge	**Assessment Methods**	**GMP**
Knowledge of spectrum of professional and complementary therapies available, e.g. palliative medicine, community services, nutritional support, pain relief, psychology of dying.	CbD	1,2
Describe different disease trajectories and prognostic indicators and the signs that a patient is dying	ACAT, CbD, mini-CEX	1
Know about Advance Care Planning documentation and End of Life Integrated Care Pathway documentation	ACAT, CbD, mini-CEX	1
Knowledge of major cultural & religious practices relevant to the care of dying people and demonstrating ability to support patients in choices relating to these	CbD, mini-CEX	1
Describe the role of the coroner and when to refer to them	CbD, mini-CEX	1
Skills		
Delivery of effective pain relief, symptom control (including for agitation, excessive respiratory secretions, nausea & vomiting, breathlessness), spiritual, social and psychological management.	MSF, CbD, mini-CEX	1
Behaviours		
Refers to specialist palliative care services when recognises that care is complex	ACAT, CbD, mini-CEX	1,2,3
Recognises the needs of the carers and is able to support them	ACAT, CbD, mini-CEX	1,2,3

Table 3: System competency – Palliative Care and End of Life Care *CMT*

Key	
A	Establishing a diagnosis
B	Establishing a diagnosis Knowledge of relevant investigations
C	Establishing a diagnosis Knowledge of relevant investigations and management Knowledge of prognosis and likely response to therapy

The trainee will acquire the defined knowledge base of clinical science and common problems with applied competences in Palliative Care

Competences	Degree of Knowledge	Assessment Methods	GMP
Take an accurate pain history		PACES, ACAT, CbD mini-CEX	1
Recognise that the terminally ill often present with problems with multi-factorial causes		MRCP(UK) Part 2, PACES ACAT, CbD, mini-CEX	1
Recognise associated psychological and social impact		MRCP(UK) Part 2, PACES ACAT, CbD, mini-CEX	
Be able to elicit patients priorities and perspectives and jointly agree a management plan with patients and their carers / family that supports these		PACES. ACAT, CbD, mini-CEX	
Recognise when a palliative care specialist opinion is needed		PACES, ACAT, CbD, mini-CEX	1
Contribute to discussions on decisions not to resuscitate with patient, carers, family and colleagues appropriately and sensitively ensuring patients interests are paramount		PACES, ACAT, CbD, mini-CEX	1,3,4
Recognise the dying phase of terminal illness		PACES, ACAT, CbD, mini-CEX	1
Manage symptoms in dying patients appropriately		MRCP(UK) Part 2, PACES ACAT, CbD, mini-CEX	1
Practice safe use of syringe drivers		ACAT, CbD, mini-CEX	1,2
Recognise importance of hospital and community Palliative Care teams		PACES, ACAT, CbD mini-CEX	1
Recognise that referral to specialist palliative care is appropriate for patients with other life threatening illnesses as well as those with cancer		PACES, ACAT, CbD mini-CEX	1
Common Problems – Palliative Care			
Pain:			
• appropriate use	B C	MRCP(UK) Part 1 and Part 2	1

• analgesic ladder	C	MRCP(UK) Part 1 and Part 2	1
• side effects	C	MRCP(UK) Part 1 and Part 2	1
• role of Radiotherapy	A	MRCP(UK) Part 2	1
Constipation	B C	MRCP(UK) Part 1 and Part 2	1
Breathlessness	B C	MRCP(UK) Part 1 and Part 2	1
Nausea and vomiting	B C	MRCP(UK) Part 1 and Part 2	1
Anxiety and depressed mood	B C	MRCP(UK) Part 1 and Part 2	1
Clinical Science			
Pharmacology of major drug classes in palliative care: anti-emetics, opioids, NSAIDS, agents for neuropathic pain, bisphosphonates, laxatives, anxiolytics		MRCP(UK) Part 1 and Part 2 PACES	1